STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE SERVICES

Before the Commissioner of Financial and Insurance Services

In the matter of

XXXXX
Petitioner **File No. 84233-001**
v

M-CARE HMO
Respondent
_____/

Issued and entered
this 17th day of December 2007
by Ken Ross
Acting Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On August 1, 2007, XXXXX, on behalf of XXXXX ("Petitioner"), filed a request for external review with the Commissioner of the Office of Financial and Insurance Services ("Commissioner") under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*.

The issue in this external review can be decided by a contractual analysis. The contract involved here is the Certificate of Coverage ("Certificate") issued by M-CARE. The Commissioner reviews contractual issues under MCL 500.1911(7). As a result, this matter does not require a medical opinion from an independent review organization.

II
FACTUAL BACKGROUND

The Petitioner became a member of M-CARE, her husband's health insurer, when she married in July 2006. On November 21, 2006, she received a routine gynecological examination from Dr. XXXXX at XXXXX in XXXXX, XXXXX. Dr. XXXXX and the XXXXX are not part of the M-CARE provider network. Petitioner requested reimbursement from M-CARE

for the services and M-CARE denied the request. Petitioner appealed through the internal grievance process and M-CARE maintained its denial. The amount in dispute is $514.00

M-CARE issued its final determination letter dated June 5, 2007.

III
ISSUE

Was M-CARE correct in denying the Petitioner coverage for the November 21, 2006 examination?

IV
ANALYSIS

Petitioner's Argument

Petitioner says that she lived in XXXXX prior to her marriage. She wanted to schedule a routine gynecological examination with her XXXXX gynecologist while she was on a visit to XXXXX. Petitioner says she contacted M-CARE before scheduling an appointment with Dr. XXXXX and asked if the appointment would be covered by M-CARE. She says the M-CARE representative told her she could see Dr. XXXXX and that the service would be covered. Petitioner says that the customer service representative even looked up the doctor's phone number for her.

The Petitioner asks that M-CARE provide coverage for all of Dr. XXXXX's services at 100% as listed in her summary of benefits due to the misinformation provided to her from M-CARE representatives.

Respondent's Argument

In its June 5, 2007 final adverse determination issued to Petitioner, M-CARE explained its denial of coverage:

> After thorough discussion of your case, the panel determined that the services provided were available within the M-CARE network. Services

rendered by non-contracted providers require prior authorization by M-CARE. Please note, future health services must be provided by in-network providers. Please refer to Section I-2.2 page 2, Section II-10 page 27 and Section III-1.1, 1.2, and 1.3 page 28 of your M-CARE HMO Certificate of Coverage.

Commissioner's Review

The requirements M-CARE imposes on members seeking coverage for treatment outside M-CARE's network are typical for HMOs. The requirements are stated in the Certificate:

I. General Terms and Conditions

* * *

2. Benefits/Policies/Procedures

* * *

2.2 Prior Authorization

Certain services and supplies under this Certificate may require Prior Authorization by M-CARE to confirm that they are Medically Necessary and Covered Services under this Certificate. A current list of those services and supplies requiring Prior Authorization is available through the M-CARE Customer Service Department at the number listed in the Member Handbook or on the Member Identification Card (or ID Card), or by visiting the M-CARE internet site at mcare.org. Claims or bills for any services that require Prior Authorization but are provided without Prior Authorization will not be paid by M-CARE.

II. Covered Services

* * *

10. Health Services Provided by Non-Contracted Providers

Unless otherwise amended by Rider, or for prior authorized follow-up care after an Emergency or Urgent care visit for Eligible Dependents who are students away at school, services provided by non-Contracted Providers are covered only if and to the extent the M-CARE network does not include a Contracted Provider who is capable of performing a service that is a Covered Service.

III. Limitations and Exclusions

The following are not Covered Services

1. General Exclusions

1.1 Unless otherwise provided by rider, services that are not provided or referred by the Primary Care Physician (other than Emergency services; routine pediatric an obstetrical/gynecological services; and services arranged by the CDR [Central Diagnostic and Referral Unit]).

1.2 Unless otherwise provided by Rider, services provided by any non-Contracted Provider (other than Emergency services or services prior authorized by M-CARE).

1.3 Services that require Prior Authorization from M-CARE or an M-CARE contractor, such as the CDR, but were not prior authorized by M-CARE contractor prior to their receipt. A current list of services that require Prior Authorization is available by calling M-CARE's Customer Service Department at the number listed in the Member Handbook or on the ID Card or by visiting the M-CARE internet site at mcare.org.

These provisions support Respondent's decision that the care the Petitioner received in XXXXX from an out-of-network provider is not a benefit under the certificate of coverage.

The Petitioner has asserted that she received authorization from M-CARE for her examination in a telephone conversation with M-CARE. Under PRIRA, the Commissioner's role in this case is limited to determining whether M-CARE properly administered health care benefits under applicable statutes and the terms of health plan's policy or certificate of coverage. The Commissioner does not have the authority to rewrite the provisions of a certificate of coverage based on oral representations, even where those representations may appear to be credible. Such an outcome may be obtained from a court of general jurisdiction having equitable powers but that authority does not reside in an administrative agency such as OFIS.

V
ORDER

M-CARE's June 5, 2007, final adverse determination is upheld.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the Circuit Court for the county where the covered person resides or in the Circuit Court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner

of the Office of Financial and Insurance Services, Health Plans Division, Post Office Box 30220,

Lansing, MI 48909-7720.